AGED AND DISABLED WAIVER PROGRAM
MEDICAL NECESSITY EVALUATION REQUEST

Please return to
West Virginia Medical Institute 3001 Chesterfield Place, Charleston, WV 25304
Fax: 304-346-8948 Toll-Free Fax: 800-293-3009

Please check one: _____ Initial _____Reevaluation

APPLICANT/MEMBER INFORMATION:

Name: _____ Date of Birth: ____/_____/_____ Sex (circle one): M F

SSN: _____ Medicaid #: _____ Medicare #: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ County of Residence: _____

_____ _____

Signature of Applicant/Member **Date**

LEGAL REPRESENTATIVE, GUARDIAN OR CONTACT INFORMATION: (Required if applicant/member has Alzheimer's, dementia or a related diagnoses)

Name: _____ Phone #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Relation to Applicant/Member (check one):

_____ Guardian _____ Committee _____ Power of Attorney _____ Medical Power of Attorney _____ Durable Power of Attorney
_____ Contact Person Other _____

_____ _____

Signature of Legal Representative (no signature needed if contact person) **Date**

CASE MANAGEMENT AGENCY or FISCAL EMPLOYER AGENT INFORMATION: (Reevaluations Only)

Agency Name: _____ Case Manager/Resource Consultant: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

REFERRING PHYSICIAN'S INFORMATION: (This information may be shared with the applicant/member.)
THIS INFORMATION MUST BE LEGIBLE OR THE REQUEST WILL NOT BE PROCESSED.

Name (MD or DO only): _____ Phone #: _____ Fax #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient's Diagnoses: _____

_____

_____

Other Pertinent Medical Conditions: _____

_____

Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition? (circle one) Yes No
Specify: _____

Is the patient terminal? (circle one) Yes No

_____ _____

Signature of Physician (MD or DO only; original required) **Date (valid for 60 days)**